Senate Bill No. 634

CHAPTER 441

An act to add Section 511.4 to the Business and Professions Code, and to amend Section 10123.12 of, and to add Section 10133.66 to, the Insurance Code, relating to health insurance.

[Approved by Governor September 30, 2005. Filed with Secretary of State September 30, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

SB 634, Speier. Health insurance: claims practices.

Existing law provides for regulation of health insurers by the Insurance Commissioner. Existing law, known as the Health Care Providers Bill of Rights, imposes certain requirements and prohibitions on the relationship between providers of health care services and health insurers relative to alternative rates of payment made by insurers on behalf of covered insureds. Existing law also requires health insurance and self-insured employee welfare benefit plan disclosure forms to be provided to insureds and enrollees, and requires those disclosure forms to contain specified information.

This bill would impose additional requirements on health insurers that enter into contracts with health care providers relative to the processing and payment of claims including requiring the disclosure of specified information in electronic format to providers annually and, additionally, upon a contracted provider's request. The bill would also require a contracting agent to disclose such specified information in electronic format to providers annually and upon a contracted provider's written request. The bill would require the health insurance policy or self-insured employee welfare benefit plan disclosure forms to insureds and enrollees to contain the nature and extent of the financial liability that is or may be incurred by the insured, enrollee, or his or her family, where care is furnished by a provider that does not have a contract with the insurer or plan to provide services at an alternative rate of payment.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The billing by providers and the handling of claims by insurers are essential components of the health care delivery process.

(b) Health maintenance organizations and preferred provider organizations regulated by the Department of Managed Health Care are subject to regulations to prevent unfair payment practices against health care providers. Preferred provider organizations and other entities

regulated by the Department of Insurance are not subject to many of these regulations, leaving providers and their patients without similar protections.

(c) To ensure the appropriate payment of claims and consistent regulation of overpayment of health care services by third-party payors, this act extends many of the current protections afforded by the Legislature to providers who deliver care to health care service plan enrollees to those who deliver care to insureds.

SEC. 2. Section 511.4 is added to the Business and Professions Code, to read:

511.4. (a) A contracting agent, as defined in paragraph (2) of subdivision (d) of Section 511.1, shall beginning July 1, 2006, prior to contracting, annually thereafter on or before the contract anniversary date, and, in addition, upon the contracted provider's written request, disclose to contracting providers all of the following information in an electronic format:

(1) The amount of payment for each service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, including the year of the schedule. For any proprietary fee schedule, the contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(2) The detailed payment policies and rules and nonstandard coding methodologies used to adjudicate claims, which shall, unless otherwise prohibited by state law, do all of the following:

(A) When available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized medical societies and organizations, federal regulatory bodies, and major credentialing organizations.

(B) Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements, such as per diem hospital payments.

(C) At a minimum, clearly and accurately state the policies regarding all of the following:

(i) Consolidation of multiple services or charges and payment adjustments due to coding changes.

(ii) Reimbursement for multiple procedures.

(iii) Reimbursement for assistant surgeons.

(iv) Reimbursement for the administration of immunizations and injectable medications.

(v) Recognition of CPT modifiers.

(b) The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented

processes, so that a reasonable person with sufficient training, experience, and competence in claims processing can determine the payment to be made according to the terms of the contract.

(c) A contracting agent may disclose the fee schedules mandated by this section through the use of a Web site, so long as it provides written notice to the contracted provider at least 45 days prior to implementing a Web site transmission format or posting any changes to the information on the Web site.

SEC. 3. Section 10123.12 of the Insurance Code is amended to read:

10123.12. Every health insurer, including those insurers that contract for alternative rates of payment pursuant to Section 10133, and every self-insured employee welfare benefit plan that will affect the choice of physician, hospital, or other health care providers shall include within its disclosure form and within its evidence or certificate of coverage a statement clearly describing how participation in the policy or plan may affect the choice of physician, hospital, or other health care providers, and describing the nature and extent of the financial liability that is, or that may be, incurred by the insured, enrollee, or covered dependents if care is furnished by a provider that does not have a contract with the insurer or plan to provide service at alternative rates of payment pursuant to Section 10133. The form shall clearly inform prospective insureds or plan enrollees that participation in the policy or plan will affect the person's choice in this regard by placing the following statement in a conspicuous place on all material required to be given to prospective insureds or plan enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

It is not the intent of this section to require that the names of individual health care providers be enumerated to prospective insureds or enrollees.

If a health insurer providing coverage for hospital, medical, or surgical expenses provides a list of facilities to patients or contracting providers, the insurer shall include within the provider listing a notification that insureds or enrollees may contact the insurer in order to obtain a list of the facilities with which the health insurer is contracting for subacute care and/or transitional inpatient care.

SEC. 4. Section 10133.66 is added to the Insurance Code, to read:

10133.66. A health insurer shall comply with all the following:

(a) Deadlines shall not be imposed for the receipt of a claim from a professional provider who submits a claim on behalf of an insured or pursuant to a professional provider's contract with a health insurer that is less than 90 days for contracted providers and 180 days for noncontracted providers after the date of service, except as required by any state or federal law or regulation. If a health insurer is not the primary payor under coordination of benefits, the insurer shall not impose a deadline for submitting supplemental or coordination of benefits claims to any

secondary payor that is less than 90 days from the date of payment or date of contest, denial, or notice from the primary payor. A health insurer that denies a claim because it was filed beyond the claim filing deadline shall, upon provider's demonstration of good cause for the delay, accept and adjudicate the claim according to Section 10123.13 or 10123.147, whichever is applicable. This subdivision shall not alter or affect any rights providers may have under any applicable statute of limitations or antiforfeiture provisions available under the laws of the State of California.

(b) Reimbursement requests for the overpayment of a claim shall not be made, including requests made pursuant to Section 10123.145, unless a written request for reimbursement is sent to the provider within 365 days of the date of payment on the overpaid claim. The written notice shall clearly identify the claim, the name of the patient, and the date of service, and shall include a clear explanation of the basis upon which it is believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

(c) The receipt of each claim shall be identified and acknowledged, whether or not complete, and the recorded date of receipt shall be disclosed in the same manner as the claim was submitted or provided through an electronic means, by telephone, Web site, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the insurer's receipt of the claim and the recorded date of receipt within 15 working days of the date of receipt of the claim by the office designated to receive the claim.

If a claimant submits a claim to a health insurer using a claims clearinghouse, its identification and acknowledgment to the clearinghouse within the timeframes set forth above shall constitute compliance with this section.

(d) Beginning July 1, 2006, prior to contracting, annually thereafter on or before the contract anniversary date, and in addition, upon the contracted provider's written request, the health insurer shall disclose to contracting providers all of the following information in an electronic format:

(1) The amount of payment for each service to be provided under the contract, including any fee schedules or other factors or units used in determining the fees for each service. To the extent that reimbursement is made pursuant to a specified fee schedule, the contract shall incorporate that fee schedule by reference, including the year of the schedule. For any proprietary fee schedule, the contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

(2) The detailed payment policies and rules and nonstandard coding methodologies used to adjudicate claims, that shall, unless otherwise prohibited by state law do all of the following:

(A) When available, be consistent with Current Procedural Terminology (CPT), and standards accepted by nationally recognized

medical societies and organizations, federal regulatory bodies, and major credentialing organizations.

(B) Clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments.

(C) At a minimum, clearly and accurately state the policies regarding all of the following:

(i) Consolidation of multiple services or charges, and payment adjustments due to coding changes.

(ii) Reimbursement for multiple procedures.

(iii) Reimbursement for assistant surgeons.

(iv) Reimbursement for the administration of immunizations and injectable medications.

(v) Recognition of CPT modifiers.

The information disclosures required by this section shall be in sufficient detail and in an understandable format that does not disclose proprietary trade secret information or violate copyright law or patented processes, so that a reasonable person with sufficient training, experience, and competence in claims processing can determine the payment to be made according to the terms of the contract.

A health insurer may disclose the fee schedules mandated by this section through the use of a Web site so long as it provides written notice to the contracted provider at least 45 days prior to implementing a Web site transmission format or posting any changes to the information on the Web site.

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